

DEPARTMENT OF HEALTH SERVICES

P.O. BOX 942732

SACRAMENTO, CA 94234-7320



Date: _____

Dear CHDP Provider:

The attached PM 160(s) cannot be processed for payment for the reason(s) indicated below. Please note that, when making corrections or additions to a PM 160 or a DHS 4073 (for dates of service prior to January 1, 2004), the person doing so must initial each change.

There may be other errors, so please review your claim carefully before returning it to the Claims Processing Contractor. Return the corrected forms to:

Medi-Cal/CHDP
Fiscal Intermediary
P.O. Box 15300
Sacramento, CA 95851-1300

Please contact your local CHDP program, if necessary, for instructions or additional information regarding your claim(s). Thank you.

I. PM 160 Confidential Screening/Billing Report

- A. Provider of Service Information Section
- ☐ (1) Number omitted, incomplete, or illegible
- ☐ (2) Name and/or address omitted, incomplete, or illegible
- ☐ (3) Signature omitted or not original
- ☐ (4) Other: _____
- B. Provider Information Section
- ☐ (1) Omitted, incomplete, or illegible
- ☐ (2) Other: _____
- C. Patient Eligibility Section
- ☐ (1) Omitted, incomplete, or illegible
- ☐ (2) Indicates DHS 4073 must accompany claim (for dates of service prior to January 1, 2004)
- ☐ (3) Other: _____
- D. Obsolete Form
- ☐ (1) PM 160 (HSP) for Head Start/State Preschools will not be processed for dates of service after December 31, 2003

II. CHDP Eligibility Information Form (DHS 4073)

The DHS 4073 must:

- ☐ (1) Have original signature—photocopy is not acceptable
- ☐ (2) Be completed: i.e., each question answered
- ☐ (3) Be signed by a parent or guardian
- ☐ (4) Be accompanied by PM 160 (for dates of service prior to January 1, 2004)
- ☐ (5) Be a version dated prior to 2003 (see footer in bottom left-hand corner for date)
- ☐ (6) Other: _____

III. Other (Please explain.)
